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No. 93-1944

In the Supreme Court of the United States

OCTOBER TERM, 1994

ABBAS ASSAR, M.D.,
Petitioner,

v.

CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE
and
CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF FOR CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE AND CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION IN OPPOSITION

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QUESTION PRESENTED

Whether this Court should review the Seventh Circuit's determination that Petitioner's *Bivens* claim for money damages for alleged constitutional violations arising from the administration of the peer review portion of the Medicare program is precluded by the existence of a comprehensive statutory and regulatory remedial mechanism, where the court of appeals carefully analyzed Petitioner's claim in light of *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), and related cases, and where its ruling is consistent with the decisions of other courts of appeals.

RULE 29.1 STATEMENT

Crescent Counties Foundation for Medical Care is an Illinois not-for-profit corporation. It has no parent company or non-wholly-owned subsidiaries.

Central Illinois Medical Review Organization is an Illinois not-for-profit corporation. It has no parent company or non-wholly-owned subsidiaries.

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BRIEF FOR CRESCENT COUNTIES FOUNDATION FOR MEDICAL CARE AND CENTRAL ILLINOIS MEDICAL REVIEW ORGANIZATION IN OPPOSITION

Respondents Crescent Counties Foundation for Medical Care ("CCFMC") and Central Illinois Medical Review Organization ("CIMRO") submit this brief in opposition to the petition for a writ of certiorari.

JURISDICTION

The judgment of the court of appeals was entered on December 29, 1993. The court of appeals denied a petition for rehearing on March 9, 1994. The petition for a writ of certiorari was filed on June 6, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

OPINION BELOW

The opinion of the court of appeals (Pet. App. 1a-11a) is reported at 13 F.3d 215. The order of the district court (Pet. App. 12a-21a) is unreported.

STATEMENT

Petitioner sought to bring a *Bivens* claim for money damages for alleged constitutional violations resulting from the Respondents' administration of the peer review portion of the Medicare program. The Seventh Circuit affirmed the dismissal of this claim, concluding that under *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), and related cases, Congress had denied Petitioner a *Bivens* remedy by creating a comprehensive mechanism to redress injuries in the peer review system. In reaching this conclusion, the court of appeals applied well-established precedent to circumstances that are virtually indistinguishable from what this Court reviewed in *Chilicky*. The Seventh Circuit's opinion is consistent with the

decisions of both this Court and the lower courts. Accordingly, the petition for a writ of certiorari should be denied.

A. Peer Review Organizations and the Medicare Review Scheme

Under the Medicare statutory scheme, peer review organizations ("PROs") perform several functions critical to "the effective, efficient, and economical delivery of health care services." 42 U.S.C. § 1395y(g).[1] A "utilization and quality control peer review organization" under 42 U.S.C. § 1320c *et seq.* consists of a representative group of physicians with different specialties from a given locality. 42 U.S.C. § 1320c-1. One PRO from each state contracts with the Health Care Financing Administration ("HCFA") of the Department of Health and Human Services ("HHS"). In turn, this PRO can subcontract with other PROs so that the statutory objectives are fulfilled. 42 U.S.C. § 1320c-2(c)(1). CCFMC provides federal Medicare peer review services in Illinois pursuant to a contract with HHS. At all times relevant to this action, CIMRO was a PRO subcontractor to CCFMC.

PROs perform numerous functions within the Medicare scheme, see generally 42 U.S.C. § 1320c-3 (defining the functions of PROs); however, their central responsibilities are three-fold. First, PROs review a hospital's participation in the Medicare program to determine whether the hospital's services are medically necessary and allowable. 42 U.S.C. § 1320c-3(a)(1). Second, PROs review whether the amounts

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[1] Because Petitioner challenges conduct occurring in 1989, Respondents have cited versions of the statutory provisions and regulations governing PROs that were current in 1989. The most relevant of these statutes and regulations are reprinted in Respondents' Appendix.

charged by individual physicians should be paid. 42 U.S.C § 1320c-3(a)(2). Finally, PROs play a role in ensuring that the physicians who participate in the Medicare program live up to their statutory duty that services:

> (1) will be provided economically and only when, and to the extent, medically necessary;
>
> (2) will be of a quality which meets professionally recognized standards of health care; and
>
> (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

42 U.S.C. § 1320c-5(a)(1)-(3).

It is this last function which is most directly relevant to this petition. Under the statute and its accompanying regulations, a PRO is empowered to recommend that a physician be sanctioned for violating the obligations to provide appropriate care to Medicare beneficiaries. 42 U.S.C. § 1320c-5(b)(1); 42 C.F.R. §§ 1004.40 to 1004.80. At the times relevant to this case, the statutes and regulations set up a multi-step process through which sanctions were imposed, involving the PRO, the Office of the Inspector General ("OIG") of HHS, agency administrative law judges and appeals panels, and the federal courts.

Once it has identified a violation of the Medicare duties and has identified the violator, a PRO is required, as the initial phase in the sanction process, to "determine the nature of the violation." 42 C.F.R. § 1004.40. If it determines that "a substantial violation in a substantial number of cases" has occurred, the PRO may recommend to the physician, in appropriate circumstances and at its discretion, "a suggested

method for correcting the situation and a time period for corrective action." 42 C.F.R. § 1004.40(b)(4). For "gross and flagrant" violations, 42 C.F.R. § 1004.1(b), the policy of HCFA at the time was also to encourage PROs and physicians to undertake corrective action in those circumstances where there was discovered a single gross and flagrant violation. See R. 24, First Amended Complaint (hereinafter "1st Am. Compl."), Ex. 6 at 2-3.[2] Through these corrective actions, the physician could choose to avoid a sanction that could preclude altogether his or her participation in the Medicare program. See 42 C.F.R. §§ 1004.60, 1004.70.[3]

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[2] In a letter to Petitioner's counsel dated December 9, 1991, Sina Ann Mercado of HCFA's Division of Health Standards and Quality described the agency's policy regarding the initiation of the sanction process when the PRO determined that a physician had committed a single "gross and flagrant" violation:

> On September 1, 1988 the PRO requested a contract modification to provide discretion in the initiation of the sanction process for single confirmed gross and flagrant issues as provided for in the Third Scope of Work (attachment A). Approval by HCFA was granted for this request on October 20, 1988. On January 21, 1989, Dr. Assar's case was confirmed as gross and flagrant at the second level of review. The Quality Peer Review Committee (QPRC) upheld the gross and flagrant designation and assigned a CAP [Corrective Action Plan] on August 8, 1989.

1st Am. Compl. Ex. 6 at 2-3.

[3] In 1990, section 1320c-5(b)(1) was amended to direct that a PRO should also provide to the practitioner, "if appropriate, . . . a reasonable opportunity to enter into and complete a corrective action plan." 42 U.S.C. § 1320c-5(b)(1) (as amended by Pub. L.

If the physician chooses not to undergo or complete the corrective action that is recommended, then additional sanction proceedings under the Medicare scheme can be triggered, including several levels of appeal. See, *e.g.*, 42 C.F.R. §§ 1004.60, 1004.70 (PRO recommendation of sanction to OIG); 42 U.S.C. § 1320c-5(b)(1); 42 C.F.R. § 1004.90(b) (OIG determination); 42 C.F.R. § 1004.90(d) (guidelines for imposition of sanction by OIG); 42 C.F.R. § 1004.90(e) (timeframe for exclusion sanction). An extensive appeals process is available from the OIG's determination. See, *e.g.*, 42 C.F.R. § 1004.130(a)(1) (ALJ); 42 C.F.R. § 498.80 (Appeals Council).[4] Under 42 U.S.C. § 1320c-5(b)(4), recourse to the federal courts under 42 U.S.C. § 405(g) is also available after the department takes its final action.

At each step in the process, the physician has the opportunity to be heard. He or she can decline to participate in a corrective action plan and instead opt for the additional steps in the sanction process. See, *e.g.*, 42 U.S.C. § 1320c-5(b)(1); 42 C.F.R. § 1004.50 (opportunity for discussion prior to submission of sanction recommendation to OIG); 42 C.F.R. § 1004.60(b)(2) (submission of additional information to OIG). And, of course, the appeals process provides for input from the physician as well.

No. 101-508, § 4205(a)(1)(A), 104 Stat. 1388-112 (1990)). This amendment codifies the preexisting policy, followed here, of allowing PROs the opportunity to suggest corrective action to physicians in appropriate circumstances.

[4] In January 1992 these regulations were modified to provide additional procedural protections during the appeals process. See 42 C.F.R. Part 1005 (1993).

B. Petitioner's Allegations

Petitioner's complaint centered on this sanction process and the two PROs' conduct during it. The core of his allegations was that on or around August 8, 1989, CIMRO alleged that Petitioner provided substandard medical care to a Medicare patient and supposedly issued a "gross and flagrant" deficiency against him. 1st Am. Compl. at Ct. II, ¶ 7. He then asserted that on September 6, 1989, the two PROs allegedly sanctioned him by imposing "practice restrictions," which supposedly limited his "rights and abilities to care for Medicare patients under the federal Medicare program." *Ibid.* These alleged restrictions were a Corrective Action Plan ("CAP"). See *id.*, Exhs. 1, 3, 4, 6.

Petitioner contended that the PROs violated the sanction procedures by failing to forward a report of the "gross and flagrant" violation to plaintiff and to the OIG, 1st Am. Compl. at Ct. II, ¶¶ 8 & 9, and that the "review actions, penalties, [and] restrictions" were instituted with malice. *Id.* at ¶ 11. He also claimed that the PROs' alleged failure to follow the statute and regulations "constructively and effectively prevented him from appealing . . . through administrative review or judicial review." *Id.* at ¶ 15. In Count III of the First Amended Complaint, Petitioner charged that through this alleged conduct, CIMRO and CCFMC violated the Constitution.[5] He sought money

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[5] Petitioner's complaint included two additional counts against CCFMC and CIMRO seeking damages for alleged common law torts and violations of various federal statutes and regulations arising from the CAP. Although the precise substance of these counts is uncertain, see Pet. App. 6a, they include allegations resembling defamation and negligence. Petitioner does not challenge the district court's dismissal of these counts, see Pet.

damages under *Bivens* v. *Six Unknown Federal Narcotics Agents*, 403 U.S. 388 (1971), for these alleged constitutional violations.

Several additional aspects of Petitioner's complaint are relevant. First, Exhibit 1 of the First Amended Complaint showed several "substantial" violations of Petitioner's Medicare duties which the PRO also could address through "corrective action" pursuant to 42 C.F.R. § 1004.40(b)(4). In addition, as discussed above, HHS policy at the time relevant to this suit provided that the PROs could exercise "discretion in the initiation of the sanction process for single confirmed gross and flagrant issues" by suggesting corrective action. 1st Am. Compl., Ex. 6 at 2-3. Indeed, according to the complaint, HCFA granted a "contract modification" to allow the PROs to exercise their discretion. *Ibid.*

Second, Petitioner elected to participate in the Corrective Action Plan provided by CIMRO, and this plan has been closed. 1st Am. Compl., Ex. 6 at 4. By participating in this plan, Petitioner avoided more restrictive sanctions that could have precluded altogether his participation in the Medicare program.

Third, according to the complaint, Petitioner waited until August 1991 to contact HHS and "request[] an immediate review by HCFA to determine the appropriateness of the actions taken by the PRO." 1st Am. Compl., Ex. 4 at 11, & Ct. II, ¶ 16. This request was approximately two years after Petitioner's Corrective Action Plan was suggested by CIMRO and accepted by him.

App. 6a-7a; consequently, they are not a subject of this petition.

C. Proceedings Below

Petitioner filed his original complaint against CCFMC and CIMRO in the United States District Court for the Central District of Illinois on May 20, 1992, and he filed a First Amended Complaint on August 4, 1992. CCFMC and CIMRO moved to dismiss both complaints contending that Petitioner failed to state a claim because a *Bivens* action was barred by the Medicare program's comprehensive statutory and regulatory remedial mechanism. See *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988). CCFMC and CIMRO also argued that they are protected by absolute immunity for their activities relating to the Medicare sanction process. See, *e.g.*, *Kwoun* v. *Southeast Missouri Prof. Standards Review Org.*, 811 F.2d 401 (8th Cir. 1987), cert. denied, 486 U.S. 1022 (1988).

On October 6, 1992, the district court issued an order dismissing Petitioner's complaint. Pet. App. 12a-21a. The court concluded that Petitioner's *Bivens* claims were barred by *Chilicky* and, since no other source for federal jurisdiction was cited apart from 28 U.S.C. § 1331, no subject matter jurisdiction existed over Petitioner's complaint. The district court did not address the immunity claim Respondents raised in their motions to dismiss.

Petitioner filed a notice of appeal to the United States Court of Appeals for the Seventh Circuit on October 29, 1992. In an opinion dated December 29, 1993, the Seventh Circuit affirmed the district court, concluding that the extensive remedial mechanism Congress established to resolve claims arising from the PRO program precluded Petitioner's claim for money damages. See Pet. App. 1a-11a.

The court of appeals began its analysis by explaining in detail both Petitioner's complaint and the multiple layers of review within both HHS and the federal courts that oversee

the work of the PROs. See Pet. App. 2a-6a. It then discussed the governing precedents, including *Chilicky* and the Tenth Circuit's opinion in *Hilst* v. *Bowen*, 874 F.2d 725, 727-28 (10th Cir. 1989), both of which found that a *Bivens* claim had been barred by the comprehensive remedial mechanisms of the Social Security system. The court concluded that in light of the remedies Congress had created, a *Bivens* claim for damages was not available. It noted that

> [a]s was true in *Chilicky* and *Hilst*, Congress has created a comprehensive scheme by which physicians can obtain review of PRO decisions affecting their participation in the Medicare program. As in those cases, the harm resulting from the alleged constitutional violation is indistinguishable from the harm resulting from the denial of the statutory right. The fact that the particular remedy Assar seeks is unavailable under the existing framework does not justify creation of a *Bivens* remedy.

Pet. App. 10a. The court of appeals also observed that although Petitioner claimed that this remedial scheme was not available to him, he also admitted that he could have sought mandamus to gain access to the scheme, if he believed that access was wrongfully denied him. Pet. App. 10a-11a.

REASONS FOR DENYING THE WRIT

The question in this case is whether the court of appeals properly applied *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), and related cases when it concluded that the Social Security Act's comprehensive scheme to redress constitutional violations that occur during administration of the Medicare program precluded Petitioner's *Bivens* claim for money damages. Petitioner does not challenge that these comprehen-

sive remedies would prevent him from bringing a *Bivens* claim. Nor could he make this argument given the multiple layers of review Congress and HHS created to oversee the conduct of PROs.

Instead, his sole argument in support of certiorari is the assertion that he somehow could not gain access to these remedies and therefore he should have a right to sue Respondents for money damages. The problem with Petitioner's claim, however, is that it ignores reality. Both the district court and the court of appeals correctly determined that Petitioner affirmatively *could* have availed himself of the Act's comprehensive remedies if he had wished to do so. In fact, Petitioner enjoyed several avenues by which he could have sought relief. Also, contrary to Petitioner's assertions, the courts of appeals have been uniform in their application of *Chilicky* and related cases. Absolutely no division exists among the lower courts on issues relevant to this case.

I. THE COURT OF APPEALS' DECISION IS WHOLLY CONSISTENT WITH THIS COURT'S PRECEDENTS

In *Bivens* v. *Six Unknown Federal Narcotics Agents*, 403 U.S. 388 (1971), this Court recognized that an action for money damages can exist against federal officials for violations of the Constitution. However, the Court also cautioned that in certain circumstances, "special factors" can "counsel[] hesitation" in implying a money remedy "in the absence of affirmative action by Congress." *Id.* at 396.

In *Bush* v. *Lucas*, 462 U.S. 367 (1983), the Court identified one of these "special factors" that can preclude a *Bivens* remedy. There the Court refused to allow a claim for money damages to go forward against federal officials who allegedly violated the First Amendment rights of a government employee. Because this claim arose "out of an employment

relationship that is governed by comprehensive procedural and substantive provisions giving meaningful remedies against the United States," the Court determined that it would be "inappropriate . . . to supplement that regulatory scheme with a new judicial remedy." *Id.* at 368. Instead, by setting up "an elaborate remedial system that has been constructed step by step, with careful attention to conflicting policy considerations," Congress had determined conclusively what remedies should exist for the aggrieved employee. *Id.* at 388. Because Congress, and not the Court, "is in a better position to decide whether or not the public interest would be served by creating" a remedy for money damages, the Court declined to allow a *Bivens* remedy. *Id.* at 390.

In *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), the Court applied these principles to bar the *Bivens* claim of Social Security recipients for money damages for, *inter alia*, "emotional distress and for loss of food, shelter and other necessities." *Id.* at 418-19. The Court concluded that a *Bivens* remedy had been barred by the comprehensive "administrative structure and procedures" of the Social Security system, *id.* at 424, through which "Congress . . . has addressed the problems created by state agencies' wrongful termination of disability benefits," *id.* at 429. This administrative scheme included several levels of agency review of benefits determinations, and, like the scheme governing PRO review, also provided for judicial review in the courts under 42 U.S.C. § 405(g). *Id.* at 424. The Court noted that "[i]n light of the comprehensive statutory schemes involved, the harm resulting from the alleged constitutional violation can in neither case be separated from the harm resulting from the denial of the statutory right." *Id.* at 428. Although the administrative scheme created by Congress did not provide a remedy for the plaintiffs' claims for money damages, the Court determined that this fact in itself was not

enough to infer the existence of a *Bivens* remedy. Despite the fact that the remedy it created was incomplete (*i.e.*, no money damages), "Congress . . . has not failed to provide meaningful safeguards or remedies for the rights of persons situated as respondents were." *Id.* at 425. The Court concluded by reasoning that

> Congress . . . has addressed the problems created by state agencies' wrongful termination of disability benefits. Whether or not we believe that its response was the best response, Congress is the body charged with making the inevitable compromises required in the design of a massive and complex welfare benefits program. Congress has discharged that responsibility to the extent that it affects the case before us, and we see no legal basis that would allow us to revise its decision.

Id. at 429 (citation omitted).[6]

The court of appeals' decision in this case is wholly consistent with this Court's precedent. First, Petitioner's "injury" originated from CIMRO's alleged failure "to follow proper statutory and regulatory procedures when it found him in violation of certain quality of care requirements." Pet. App. 2a. Here, as in *Chilicky* and *Bush*, "the harm resulting

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[6] Recently, in *FDIC* v. *Meyer*, 114 S. Ct. 996 (1994), this Court unanimously refused to allow a *Bivens* claim to go forward directly against a federal agency, noting that its recent decisions have "'responded cautiously to suggestions that *Bivens* remedies be extended into new contexts.'" *Id.* at 1005 (quoting *Chilicky*, 487 U.S. at 421). This Court also observed that caution should be exercised when recognizing new *Bivens* actions because of the potentially enormous financial burden to the federal government that these remedies could create. *Id.* at 1006.

from the alleged constitutional violation can in neither case be separated from the harm resulting from the denial of the statutory right." *Chilicky*, 487 U.S. at 428. In addition, as in *Chilicky* and *Bush*, Congress has created an extensive procedure to review the PROs' conduct. See pp. 2-5 *supra*. This multi-level scheme is almost identical to the one the *Chilicky* Court concluded was sufficient to bar a *Bivens* action. It is also more extensive than the scheme the *Bush* Court determined was adequate to bar a claim for money damages. See *Chilicky*, 487 U.S. at 425. This review scheme also shares many elements with the one that the Tenth Circuit in *Hilst* v. *Bowen*, 874 F.2d 725, 727-28 (10th Cir. 1989), determined was a "comprehensive remedy . . . provided to physicians when their right to participate in the Medicare program is suspended," and which precluded a *Bivens* claim for damages resulting from a physician's suspension from the program. Given the comprehensiveness of the scheme governing PRO conduct, it is apparent that Congress intended the statutory and regulatory Medicare framework to be the exclusive remedy for claims arising out of the PRO system. The court of appeals therefore correctly determined that, as a matter of law, a *Bivens* action for money damages is unavailable to Petitioner.[7]

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[7] Although the court of appeals did not reach the issue, CCFMC and CIMRO also argued that the judgment of the district court could be affirmed on the ground that Respondents enjoy absolute immunity for claims arising from their review of physicians in the Medicare program. See, *e.g.*, *Kwoun* v. *Southeast Missouri Prof. Standards Review Org.*, 811 F.2d 401, 409 (8th Cir. 1987) (recognizing absolute immunity for PROs), cert. denied, 486 U.S. 1022 (1988). This absolute immunity for PROs was a separate and independent ground to affirm the judgment of the district court. The existence of this other basis to support the decision of the

II. *PETITIONER HAD ACCESS TO CONGRESS'* CAREFULLY WROUGHT ADMINISTRATIVE REVIEW SCHEME

Petitioner does not really dispute that the extensive scheme governing PRO reviews would preclude him from bringing a *Bivens* action for money damages. Indeed, he himself describes the scheme as "comprehensive," "elaborate," and "extensive." Pet. 5, 7, 8, 9; see also Pet. 10 ("Congress did construct a system which would normally protect individuals like Petitioner with meaningful safeguards and remedies").

Instead, Petitioner argues that this case is distinguishable because Respondents allegedly prevented him from getting the benefit of the administrative review procedures. According to Petitioner, "[t]he only thing that [he] wanted was to appeal Respondents' decision to restrict his ability to care for Medicare patients" and "Respondents refused to allow him to do so." Pet. 5.

For several reasons, this argument does not stand up to scrutiny. First, as this Court has held, "[w]hen the design of a Government program suggests that Congress has provided what it considers adequate remedial mechanisms for constitutional violations that may occur in the course of its administration," a *Bivens* remedy will not be created. *Chilicky*, 487 U.S. at 423. As demonstrated above, Congress has created an exhaustive set of procedures to review the actions of PROs. In light of the obvious care that Congress has brought to this issue there is no basis for Petitioner to argue that a remedy for money damages should be engrafted onto Congress' scheme. *Id.* at 429.

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district court is another reason for denying Petitioner's request for certiorari.

Second, Petitioner's claim that he was barred from the remedial scheme is simply not true. As both the court of appeals and the district court concluded, Petitioner could have sought to demand Respondents' compliance with the scheme, if he believed that he was wrongfully denied access to it. Although this remedy would not have provided Petitioner the money damages that he wants in this lawsuit, it could have allowed him to demand that the PROs follow the statute and regulations, which would alleviate the precise injury that he claims he received.

As the lower courts observed — and as Petitioner appears to concede (Pet. 9) — Petitioner could have sought to require Respondents to follow the proper administrative procedures by seeking mandamus under 28 U.S.C. § 1361. This mandamus relief would not have given Petitioner the money damages that he seeks, but it presumably would have obtained for him the procedures that he claims he is due.

In addition, as CCFMC argued to the court of appeals, if Petitioner was dissatisfied with the conduct of the PROs, he had the opportunity to gain immediate redress by bypassing those organizations and contacting HHS directly with his complaints. HHS, in turn, could have provided him with the relief he seeks either by enforcing the terms of the PROs' contracts (if HHS concluded there had been a violation of those contracts) or by invoking 42 U.S.C. § 1320c-2, terminating the contracts (again, assuming HHS found a violation), and transferring the PROs' responsibilities to another organization. See *Kwoun* v. *Southeast Missouri Prof. Standards Review Org.*, 811 F.2d 401, 409 (8th Cir. 1987), cert. denied, 486 U.S. 1022 (1988).

Finally, Petitioner has taken the position throughout this litigation that he has exhausted his administrative remedies. See 1st Am. Compl. at Ct. II, ¶ 16 ("The Plaintiff. . . has

exhausted all administrative appeal remedies"); Pet. App. 5a-6a. Taking Petitioner at his word, if he had exhausted his remedies he presumably could have sought judicial review of his situation through 42 U.S.C. § 405(g) and 42 U.S.C. § 1320c-5(b)(4). Although this review would not have allowed the money damages provided through a *Bivens* action,[8] it would have provided relief within the bounds of the statutory scheme created by Congress, and would bar a *Bivens* claim. See *Hilst*, 874 F.2d at 727-28.

Petitioner's only response is to assert that it is "unrealistic to presume" that he or others would bring a mandamus action. Pet. 9. However, he does not explain why it is more unrealistic to think that a person would bring a mandamus action (or seek administrative routes of review) than to think that he or she would bring a *Bivens* claim. Filing a *Bivens* action is arguably much more difficult than taking a grievance to HCFA officials, and certainly no easier than other types of litigation such as mandamus or review under section 405(g). But, in the end, this question of ease of use is beside the point. Under *Chilicky*, 487 U.S. at 423, the relevant inquiry is whether or not Congress provided the Petitioner with what Congress believed to be a sufficient remedial scheme. Once Congress established this scheme, whether its remedies would fully compensate Petitioner and whether its

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[8] Section 405(g) is a mechanism whereby a litigant may challenge the constitutionality of actions taken under the Social Security Act. See *Mathews* v. *Eldridge*, 424 U.S. 319, 332 (1976). The statute, however, does not provide for money damages against officials responsible for unconstitutional conduct. See also *Chilicky*, 487 U.S. at 424-25 (claimants whose benefits are restored through the administrative process lack standing to invoke the Constitution under the statute's administrative review provision); *Hilst*, 874 F.2d at 727-28.

procedures would be easy or difficult to use do not figure into the analysis.

Petitioner also argues that he should receive a *Bivens* remedy because "[f]orcing Respondents to follow Congress' theme [*sic*] at this point is moot." Pet. 5. However, the record reflects that the Corrective Action Plan Petitioner objects to was suggested in August 1989, and Petitioner did not contact HCFA with his complaints until 1991 and did not file any legal challenge to his situation until 1992, after the CAP had closed. The only reason petitioner is in desperation now is that he failed to seek other remedies in a timely fashion, and the CAP ended. Surely Petitioner's failure to take advantage of the comprehensive remedial scheme in a timely fashion cannot be grounds for allowing him a *Bivens* remedy after the fact. Giving him relief in this situation would be an incentive *not* to follow the carefully wrought system that Congress has created.

III. NO DISAGREEMENT EXISTS AMONG THE LOWER COURTS

Petitioner also claims that the Seventh Circuit's opinion conflicts with the decisions of the Federal Circuit in *Ysasi* v. *Rivkind*, 856 F.2d 1520 (Fed. Cir. 1988), and the Eighth Circuit in *Glasgow* v. *United States Drug Enforcement Administration*, 12 F.3d 795 (8th Cir. 1993). No conflict exists among these decisions.

First, it should be emphasized that neither *Glasgow* nor *Ysasi* discusses the Social Security Act or the peer review system under the Medicare program. To the extent that these cases analyze other statutes with distinct remedial schemes, they cannot call into question the court of appeals' decision that the comprehensive remedial scheme governing PRO reviews bars Petitioner's *Bivens* claim.

In addition, nothing in the reasoning of these cases conflicts with the Seventh Circuit's opinion. In *Glasgow*, the sum total of the discussion of *Chilicky* is the court's refusal to affirm the district court's summary conclusion that the forfeiture remedies under the Tariff Act were sufficiently comprehensive to bar a *Bivens* claim. *Glasgow*, 12 F.3d at 799. Given the brief discussion of *Chilicky* in the Eighth Circuit's opinion, it is simply puzzling why Petitioner believes that *Glasgow* demonstrates a division among the circuits.[9]

Ysasi likewise does not conflict with the Seventh Circuit's opinion. *Ysasi* does indeed contain language stating that a *Bivens* remedy may be available when the plaintiff is unable to pursue alternative remedies. However, leaving aside whether this is an accurate statement of the law, this language does not assist Petitioner.

First, as discussed above, Congress created an intricate and comprehensive remedial mechanism governing peer review under the Social Security Act, and thereby precluded

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[9] To the extent it is even relevant to this case, *Glasgow* is consistent with the Seventh Circuit's opinion. Both in this case and in *Glasgow*, the court applied *Chilicky* to determine whether a statutory scheme's remedies were sufficiently comprehensive to demonstrate that Congress intended to bar an action for money damages. Here, the Seventh Circuit, following *Chilicky*, decided that the detailed remedies of the Medicare program indicated that Congress precluded an action for money damages. See Pet. App. 7a-11a. In *Glasgow*, the court decided that it could not determine without further analysis whether the protections of a different statute prevented a *Bivens* remedy. See *Glasgow*, 12 F.3d at 799. The decisions simply apply the same principles to different factual and legal settings. There is nothing in their reasoning that is in conflict.

Petitioner from bringing a *Bivens* claim even if that mechanism did not give him complete relief for his alleged injuries. See *Chilicky*, 487 U.S. at 429. In addition, as both the district court and the court of appeals determined, Petitioner could have sought relief within the statutory scheme that Congress created, if only he had pursued these remedies. In fact Petitioner himself admits that he could have sought mandamus to gain the appeals that he claims he was denied.

Also, *Ysasi* arose in a factual setting that is markedly different from the one in this case. The *Ysasi* court based much of its analysis on the fact that the truck that the plaintiff was seeking to recover had been transferred irremediably to a lienholder before Ysasi could have filed his administrative claims. The court concluded that once possession of the truck had been transferred, "[i]t would have been pointless for Ysasi" to pursue any alternative remedies. *Ysasi*, 856 F.2d at 1527.

Here, unlike in *Ysasi*, it did not become "pointless" for Petitioner to try and gain relief through the administrative scheme. Petitioner accepted and worked under the CAP for many months before he raised his first objection to it. At any point during this period the Petitioner could have sought review of his situation either by contacting HHS or seeking judicial review through mandamus or an action under section 405(g). The facts that Petitioner slept on his rights and did not seek relief until years later should not allow him to sue the Respondents for money damages.

Indeed, it is Petitioner's contentions that, if adopted, would conflict with existing precedents. Petitioner advocates making available wide-ranging remedies for money damages against persons administering the Social Security program who "disregard the rules and regulations Congress enacts governing that agency." Pet. 8. *Chilicky*, however, decided conclusively

that money damages are not available in these circumstances. Petitioner seeks to ignore this precedent by bringing a damages claim in a situation where Congress has affirmatively barred this remedy.

Also, as has been recently reiterated, this Court has "'responded cautiously to suggestions that *Bivens* remedies be extended into new contexts.'" *FDIC* v. *Meyer*, 114 S. Ct. 996, 1005 (1994) (quoting *Chilicky*, 487 U.S. at 421). Petitioner's attempt to inject claims for money damages into the Social Security system presents the possibility of thousands of lawsuits being brought seeking to impose personal liability on government employees. Besides clogging the courts, the mere threat of these lawsuits "would undoubtedly lead to new difficulties and expense in recruiting administrators for the programs Congress has established." *Chilicky*, 487 U.S. at 425. In addition, the funds spent both to defend these claims and to pay for any judgments would impose a new and significant burden on the Treasury. See *Meyer*, 114 S. Ct. at 1006 (noting that the Court has refused to authorize *Bivens* remedies which implicate the "federal fiscal policy" by "creating a potentially enormous financial burden for the Federal Government"). For these reasons, presumably, Congress created an exclusive remedial scheme to deal with all claims that arise from the Social Security program. Once Congress made this decision, it affirmatively barred the *Bivens* remedy Petitioner now seeks.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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APPENDIX

RELEVANT STATUTES AND REGULATIONS

Statutes

28 U.S.C. § 1254(1) (1988)

§ 1254. Courts of appeals; certiorari; certified questions

Cases in the courts of appeals may be reviewed by the Supreme Court by the following methods:

(1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree;

28 U.S.C. § 1361 (1988)

§ 1361. Action to compel an officer of the United States to perform his duty

The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

42 U.S.C. § 1395y(g) (1988)

(g) Contracts with utilization and quality control peer review organizations

The Secretary shall, in making the determinations under paragraphs (1) and (9) of subsection (a) of this section, and for the purposes of promoting the effective, efficient, and economical delivery of health care services, and of promoting the quality of services of the type for which payment may be made under this subchapter, enter into contracts with utilization and quality control peer review

organizations pursuant to part B of subchapter XI of this chapter.

42 U.S.C. § 1320c-2(c) (1988)

(c) Terms of contract

Each contract with an organization under this section shall provide that--

(1) the organization shall perform the functions set forth in section 1320c-3(a) of this section, or may subcontract for the performance of all or some of such functions (and for purposes of paragraphs (2) and (3) of subsection (b) of this section, a subcontract under this paragraph shall not constitute an affiliation with the subcontractor);

(2) the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract;

(3) the contract shall be for an initial term of three years and shall be renewable on a triennial basis thereafter;

(4) if the Secretary intends not to renew a contract, he shall notify the organization of his decision at least 90 days prior to the expiration of the contract term, and shall provide the organization an opportunity to present data, interpretations of data, and other information pertinent to its performance under the contract, which shall be reviewed in a timely manner by the Secretary;

(5) the organization may terminate the contract upon 90 days notice to the Secretary;

(6) the Secretary may terminate the contract prior to the expiration of the contract term upon 90 days notice to the organization if the Secretary determines that--

(A) the organization does not substantially meet the requirements of section 1320c-1 of this title; or

(B) the organization has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, but only after such organization has had an opportunity to submit data and have such data reviewed by the panel established under subsection (d) of this section;

(7) the Secretary shall include in the contract negotiated objectives against which the organization's performance will be judged, and negotiated specifications for use of regional norms, or modifications thereof based on national norms, for performing review functions under the contract; and

(8) reimbursement shall be made to the organization on a monthly basis, with payments for any month being made not later than 15 days after the close of such month.

In evaluating the performance of utilization and quality control peer review organizations under contracts under this part, the Secretary shall place emphasis on the performance of such organizations in educating providers and practitioners (particularly those in rural areas) concerning the review process and criteria being applied by the organization.

42 U.S.C. § 1320c-5(a) & (b) (1988)

§ 1320c-5. Obligations of health care practitioners and providers of health care services; sanctions and penalties; hearings and review

(a) Assurances regarding services and items ordered or provided by practitioner or provider

It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care

facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this chapter, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this chapter--

(1) will be provided economically and only when, and to the extent, medically necessary;

(2) will be of a quality which meets professionally recognized standards of health care; and

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

(b) Sanctions and penalties; hearings and review

(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, any organization having a contract with the Secretary under this part determines that such practitioner or person has--

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a) of this section, or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this chapter, has

demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such practitioner or person from eligibility to provide services under this chapter on a reimbursable basis. If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines otherwise.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective on the same date and in the same manner as an exclusion from participation under the programs under this chapter becomes effective under section 1320a-7(c) of this title, and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

(4) Any practitioner or person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(5) Before the Secretary may effect an exclusion under paragraph (2) in the case of a provider or practitioner located in a rural health manpower shortage area (HMSA) or in a county with a population of less than 70,000, the provider or practitioner adversely affected by the determination is entitled to a hearing before an administrative law judge (described in section 405(b) of this title) respecting whether the provider or practitioner should be able to continue furnishing services to individuals entitled to benefits under this chapter, pending completion of the administrative review procedure under paragraph (4). If the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to such individuals if permitted to continue furnishing such services, the Secretary shall not effect the exclusion under paragraph (2) until the provider or practitioner has been provided reasonable notice and opportunity for an administrative hearing thereon under paragraph (4).

Regulations

42 C.F.R. § 1004.1(b)(1988)

§ 1004.1 Scope and definitions.

(b) *Definitions.* As used in this part, unless the context indicates otherwise:

Gross and flagrant violation means a violation of an obligation has occurred in one or more instances which presents an imminent danger to the health, safety or well-being of a Medicare beneficiary or places the beneficiary unnecessarily in high-risk situations.

42 C.F.R. § 1004.40 (1988)

§ 1004.40 Action on identification of a violation.

When a PRO identifies a violation, it must determine the nature of the violation.

(a) If the PRO determines the violation as one that is gross and flagrant, it must proceed in accordance with § 1004.50.

(b) If the PRO determines the violation as a substantial violation in a substantial number of cases it must send the practitioner or other person a written initial notice of the identification of a violation containing the following information:

(1) The obligation involved.

(2) The situation, circumstances, or activity that resulted in a violation.

(3) The authority and responsibility of the PRO to report violations of obligations.

(4) At the discretion of the PRO, a suggested method for correcting the situation and a time period for corrective action.

(5) The sanction that the PRO could recommend to the OIG if the violation continues.

(6) An invitation to submit additional information to or discuss the problem with representatives of the PRO within 20 days of receipt of the notice. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(7) A summary of the information used by the PRO in arriving at its determination of a violation of an obligation.

42 C.F.R. § 1004.50 (1988)

§ 1004.50 Action on determination of a violation.

(a) *Written notice.* The PRO must give written notice to the practitioner or other person if it determines that--

(1) A substantial violation has occurred in a substantial number of cases; or

(2) A violation is gross and flagrant in one or more cases.

(b) *Contents.* The notice must contain the following information:

(1) The determination of a violation.

(2) The obligation violated.

(3) The basis for the determination.

(4) The sanction the PRO will recommend to the OIG.

(5) The right of the practitioner or other person to submit to the PRO within 30 days of receipt of the notice, additional information or a written request for a meeting with the PRO to review and discuss the determination, or both. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary.

(6) A copy of the material used by the PRO in arriving at its determination.

(c) *Review of PRO determination.*

(1) The PRO may, on the basis of additional information received, affirm, modify, or reverse its determination.

(2) The PRO must give written notice to the practitioner or other person, of any action it takes as a result of the additional information received, as specified in § 1004.60.

42 C.F.R. § 1004.60 (1988)

§ 1004.60 Final PRO determination of a violation.

If the issue is not resolved to the PRO's satisfaction as specified in § 1004.50(c), the PRO must--

(a) Submit its report and recommendation to the OIG; and

(b) Send the affected practitioner or other person a concurrent final notice, with a copy of the PRO report that is being forwarded to the OIG, advising that--

(1) The PRO recommendation has been submitted to the OIG;

(2) The practitioner or other person has 30 days from receipt of this final notice to submit any additional written material or documentary evidence to the OIG at its central

office location. The date of receipt is presumed to be five days after the date on the notice, unless there is a reasonable showing to the contrary; and

(3) Due to the 120-day statutory requirement specified at § 1004.90(e), the period for submitting additional information will not be extended and any material received by the OIG after the 30-day period will not be considered.

42 C.F.R. § 1004.70 (1988)

§ 1004.70 PRO report to OIG.

(a) *Manner of reporting.* If the PRO determines that a substantial violation has occurred in a substantial number of cases or that a gross and flagrant violation has occurred, it must submit a report and recommendation to the OIG at the regional office with jurisdiction.

(b) *Content of report.* The PRO report must include the following information--

(1) Identification of the practitioner or other persons and when applicable, the name of the director, administrator, or owner of the entity involved;

(2) The type of health care services involved;

(3) A description of each failure to comply with an obligation, including specific dates, places, circumstances, and any other relevant facts;

(4) Pertinent documentary evidence;

(5) Copies of written correspondence and written summaries of oral exchanges with the practitioner or other person regarding the violation;

(6) The PRO's determination that an obligation under section 1156(a) of the Act has been violated and that the violation is substantial and has occurred in a substantial number of cases or is gross and flagrant;

(7) The professional qualifications of the PRO's reviewers' and

(8) The PRO's sanction recommendation.

(c) *PRO Recommendation.* The PRO must specify in its report--

(1) The sanction recommended;

(2) The amount of the monetary penalty recommended, if applicable;

(3) The period of exclusion recommended, if applicable; and

(4) A recommendation as to whether the practitioner or other person is unable or unwilling substantially to comply with the obligation that was violated.

42 C.F.R. § 1004.80 (1988)

§ 1004.80 Basis for recommended sanction.

The PRO's specific recommendation must be based on a consideration of--

(a) The type of offense involved;

(b) The severity of the offense;

(c) The deterrent value;

(d) The practitioner's or other person's previous sanction record;

(e) The availability of alternative sources of services in the community; and

(f) Any other factors that the PRO considers relevant (for example, the duration of the problem).

42 C.F.R. § 1004.90 (1988)

§ 1004.90 Acknowledgement and review of report.

(a) *Acknowledgement.* The OIG will inform the PRO of the date it received the PRO's report and recommendation.

(b) *Review.* The OIG will review the PRO report and recommendation to determine whether--

(1) The PRO is following its procedures;

(2) A violation has occurred; and

(3) The practitioner or other person has demonstrated an unwillingness or lack of ability substantially to comply with an obligation.

(c) *Rejection of the PRO recommendation.* If the OIG decides that a sanction is not warranted, it will notify the PRO that recommended the sanction and the affected practitioner or other person that the recommendation is rejected.

(d) *Decision of sanction.* If the OIG decides that a violation of obligations has occurred, it will determine the appropriate sanction by considering--

(1) The recommendation of the PRO;

(2) The type of offense;

(3) The severity of the offense;

(4) The previous sanction record of the practitioner or other person;

(5) The availability of alternative sources of services in the community;

(6) Any prior problems the Medicare carrier or intermediary has had with the practitioner or other person;

(7) Whether the practitioner or other person is unable or unwilling to comply substantially with the obligations; and

(8) Any other matters relevant to the particular case.

(e) *Exclusion sanction.* If the PRO submits a recommendation for exclusion to the OIG, and a determination is not made by the 120th day after actual receipt by the OIG, the exclusion sanction recommended will become effective and the OIG will provide notice in accordance with § 1004.100(f).

(f) *Monetary penalty.* If the PRO recommendation is to assess a monetary penalty, the 120-day provision does not apply and the OIG will provide notice in accordance with § 1004.100(a) through (e).

42 C.F.R. § 1004.130 (1988)

§ 1004.130 Appeal rights.

(a) *Right to administrative review.*

(1) A practitioner or other person dissatisfied with an OIG determination or an exclusion that results from a determination not being made within 120 days is entitled to a hearing before an Administrative Law Judge and may also request a review of that decision by the Appeals Council in accordance with Part 498 of this title.

(2) Due to the 120-day statutory requirement specified at § 1004.90(e) of this part, the following limitations apply:

(i) The period for submitting additional information will not be extended.

(ii) Any material received by the OIG after the 30-day period allowed, will not be considered and will not be subject to review by the Administrative Law Judge and the Appeals Council.

(3) The OIG's determination continues in effect unless reversed by a hearing decision.

(b) *Right to judicial review.* Any practitioner or other person dissatisfied with a decision of the Appeals Council or an administrative law judge (if a request for Appeals Council review is denied) may file a civil action in accordance with the provisions of section 205(g) of the Act.